Testimony of the Connecticut Society of Eye Physicians
Before the Public Health Committee, March 5, 2007
In Opposition to
H.B. 7159 - An Act Updating the Scope of Practice of Optometry

Good Day, Senator Handley, Representative Sayers, and other members of the Public Health Committee. For the record, I am Dr. William Ehlers, a corneal specialist practicing at the University of Connecticut Health Center. I am the past president of the Connecticut Society of Eye Physicians and current President of the Contact Lens Association of Ophthalmologists. In that role, I sometimes work with Optometrists who are among the top contact lens scientists. I am also President elect of the Joint Commission on Allied Health Personnel in Ophthalmology, an organization that provides training and certification for ophthalmic technicians. I mention these things to point out that I am someone with a good understanding and appreciation of the training and talents of various members of the eye care team. Having said that, I am here today to speak in strong opposition to **H.B. 7159 - an Act Updating the Scope of Practice of Optometry**.

You have heard from my colleagues this afternoon regarding the dangerous diseases and procedures that optometrists now feel should be within their scope of practice. Disagreements between ophthalmology and optometry are not new; over the years they have occupied too much of your time and ours. To those of you who view this disagreement as a turf battle primarily motivated by economic self-interest, I urge you to look a little deeper. The Connecticut Society of Eye Physicians recently provided testimony before this committee opposing RB 5760, AAC Prevention Strategies for Vision Problems in Young Children, which would require a complete eye exam for all children before entering school – a measure that would certainly bring many new patients to our offices. Why did we oppose this measure? It would have been easy to join hands with optometry and support legislation that on first glance seems like the right thing to do, but after careful consideration, we believed that this approach was not the best approach for preventing vision problems, nor was it the best use of precious healthcare dollars, even though it would have benefited us personally. In the interest of time I will not recap our analysis, but I feel this example highlights an important distinguishing characteristic of true professionals: the ability to put the welfare of their patients and the public ahead of their own personal interests. In a similar fashion, we do not oppose this expansion of optometric scope of practice as a turf battle in which we must protect our own interests; we oppose it because it places the people of Connecticut at unnecessary risk.

Optometrists say they are professionals who should be allowed to exercise their professional judgment on matters of referral, and they don't intend to treat pediatric glaucoma or some of the other serious conditions previously excluded from their scope of practice. Are we then to understand that they simply don't want to be told what to do? Is that an appropriate reason to change the law? The fact is Optometrists are licensed to

practice optometry, not medicine. You also heard this afternoon about the differences in our education and training. Optometrists simply do not have the training to treat these serious diseases and conditions. In addition, there are adequate numbers of Ophthalmologist in Connecticut to take care of the patients with these problems.

Optometrists also say they have proven record of competent and professional treatment of eye disease under the current statutes. In fact, the true performance of optometrists is not known. There is currently no requirement for them to report claims and occurrences as exist for medical doctors. Through long experience, we know that the goal of optometry is to continue to expand their scope of practice until they in essence become ophthalmologists - a goal articulated at a meeting called Optometry 2020, held in April of 2006. I have attached a review of the goals to my testimony. They wish to achieve these goals not through medical school and residency training, but through legislative action. I am sorry if optometrists are unhappy with their career choice, but there is no rationale for the CGA to solve this problem for them. Interestingly, optometrists often take a much harder line when others attempt to expand their scope of practice. I have attached several interesting articles to my testimony in which optometrists are less than enthusiastic about the prospect of opticians performing refractometry (testing for glasses). It is perhaps important to remember that no one has gone blind or died from an incorrect pair of glasses.

The stakes are much higher here.

Make no mistake; this act is not a simple "update" to the Optometric Statutes – it is a significant and dangerous expansion of their scope of practice. When the current statutes were crafted, the lines were drawn where they are for good reasons, and those reasons have not changed. The conditions they seek to treat were not within the scope of their practice and training then, and they are not within the scope of their practice and training now.

And let's be clear on one more point: There is absolutely no medical or public health need for this legislation. Quite the contrary – this legislation places the people of Connecticut at risk. I urge you to reject it.

Thank you for your attention.

American Optometric Association
"Optometry 2020 Summit," April 2006

O.D. scope to include:

- "…diagnosis and treatment of all diseases of the eye and adnexa…"
- Use of all medications (topical, oral, injectables (peri-ocular, intra-ocular, IV)
- Unrestricted use of lasers
- Unrestricted use of scalpels
- ***Unrestricted scope as authorized by Board of Optometry***
- Nationwide, uniform, self-regulated licensure with ***available residency programs in optometric surgery.***
- Deliver care through the use of the best available eye care products and technology, with ***no restrictions on scope of practice or physical location.***
- ***Being recognized as the professional authority that defines guidelines and policies for <u>ALL</u> eye and vision issues and health care.***

O. D.'s Objective: Create an optometric surgeon through legislation and regulation - *not* through education and training.

GUEST EDITORIAL – Review of Optometry, May 1999

Will Professional Myopia Destroy Us?

by David Phillips, O.D., Blue Springs, Mo.

I may not renew my Optometric license next year. I've been thinking of becoming an optician instead. A refracting optician.

Don't get me wrong. I love optometry. I started practice before diagnostic drugs, and nearly half my professional life was pre-TPA. I have a deep appreciation for how we've emerged as a true primary eye-care profession

But it seems to me that optometry has lost its way. Traditional vision care just isn't glamorous any more. We've gotten into a mind set that demands an ever-expanding scope of practice—glaucoma this year, lasers next year, who knows what after that? We obsess about how many Rxes O.D.s are writing, and our journals fill themselves with more and more esoteric primary care.

I'm not advocating that we abandon primary care. But clinical vision care is more important to the survival of our profession than expanding the primary care boundaries. Given that there are many times more patients who need refractive care than need medical eye care, reality dictates that we are dependent on the former for our very existence.

Opticians, meanwhile, are hoping we will be so myopic as to ignore refracting and clinical vision care long enough for them to get a foot in the door. With ophthalmology's move into dispensing and managed care's desire for one-stop service, independent opticians who cannot generate their own Rxes are fighting for survival. Many among them think that refracting will be their salvation. Opticians have introduced a bill in Washington State that would allow them to refract. Similar legislation may soon be sought in Florida, New York, Nevada and Texas.

This legislation would allow refraction only "under supervision" or with other limitations. We cannot allow ourselves or our legislators to be misled; opticians' ultimate goal is to gain licensure to perform independent refractions.

What can we do? Let's examine the hollow arguments opticians have used to confound the issue:

• Eyes are healthy if they can be refracted to 20/40. I can think of 9.2 million reasons why this one is not true.[1] Under the Washington bill, opticians could alter a prescription in patients having best-corrected acuity of at least 20/40. This implies that the eyes are healthy if they can be corrected to 20/40. Otherwise,

why place a limit on acuity? But we know that no level of visual acuity proves the eyes are healthy. Acuity is not a test of eye health.

A short list of eye diseases that can be present in an eye with 20/25 or even 20/20 acuity: glaucoma, retinochoroiditis, diabetic retinopathy, histoplasmosis, wet age-related macular degeneration, Coats' disease, Stargardt's disease, choroidal tumor, pigmentary dispersion syndrome, pseudoexfoliation cataract and retinal detachment.

• Opticians are "eye care professionals." This is simply not true. It's a trade at best, but even if trades were outlawed, in most states opticians couldn't get arrested. Opticians are unlicensed and unregulated in 28 states. In states that do require a license, not all require a high school diploma. Only three states require any college education. There are two professional "O's," not three.

• Opticians will be "well-patient" refractionists. How this can be when opticians are not clinicians and are not qualified to tell whether or not a patient is well? A leading optician said it was "totally irrelevant" when confronted with a case where an optometrist saved an asymptomatic patient's life by discovering a choroidal melanoma on a routine dilated exam[2] because the patient went in for an eye exam, not just a refraction.[3] This ignores the obvious: Since independent optician refractions are not allowed, this patient did not actually choose a complete exam over a separate refraction. Our system forced him to have the exam, even though he was asymptomatic, and it saved him from the fatal mistake of having an optician "tweak" his Rx—and letting his malignancy go undiscovered. This is why the complete exam, and just not refraction, is the standard of care. It should not be changed.

• Opticians should not be held accountable for failure to diagnose, because they will be doing refractions, not exams. How great for them! But if opticians are asking to be allowed to provide a facet of health care, why shouldn't they, unlike all other health-care providers, be held accountable?

• We need optician refractionists. There is actually a surplus of eye doctors, all of whom are trained to refract. The Rand study found up to 30 percent more O.D.s than are needed.[4] The oversupply of ophthalmologists is so bad that the Health Care Financing Agency is now offers subsidies to the nation's 1,250 teaching hospitals to cut back ophthalmology residencies.[5]

• Refracting opticians would be cost-effective. In other words, the laymen are telling the doctors that preventive medical care is not cost-effective. But we know that if we let disease go until the later stages, it is more difficult and more expensive to treat.

• Opticians could become competent refractionists with a 100-hour course. The magician's trick of misdirection. They want to shift the argument to whether they

could learn to refract, when the only legitimate question is whether they should. It doesn't matter whether opticians could learn to use the phoropter, one of the eye doctor's tools, in 100 hours or even 1,000 hours. Without an eye health exam, it is a statistical certainty that a number of their "patients" will have an undiagnosed ocular and/or systemic disease to go with their new glasses.

I could spend 100 hours teaching my 17-year-old how to look up medications in the Physician's Desk Reference, another one of our tools. She could become quite competent at finding indications, side effects and interactions for various drugs. But would this make her qualified to prescribe medication for patients? Of course not.

• The opticians' 100-hour refractometry course is comparable to our 100-hour DPA or TPA courses. However, a 100-hour post-graduate course for doctors is an entirely different matter than some beginner training for non-professionals. The truth is that optometry had a generation of medically trained graduates in place before seeking an expanded scope of care. Opticianry has no such educational basis for laying claim to expanded privileges.

• Opticians "gave up" refraction decades ago. Refracting represents progress, or is a natural evolution for them. They have the history backwards. Present-day opticians are "descended" from those turn-of-the-century opticians who did not pursue refraction. Those who did pursue refraction became optometrists. There is no need to have a second batch of opticians branch off and evolve, over the next 100 years, into eye doctors. It's already been done.

• Because lay people can self-prescribe reading glasses, opticians should be able to write Rxes for glasses. This is one of my favorites. Let's follow the logic: Neosporin ointment can be purchased over the counter, so lay people can self-prescribe meds. Therefore opticians should prescribe meds!

Every O.D. should strongly oppose independent refractometry for opticians. We have a duty to every patient we examine to look after his or her health and well-being. I believe we have an equal duty to protect the public, for its own economic benefit, from having unqualified examiners doing part of the job.

Besides the public health issue, consider what would happen if opticians can refract. Sooner or later the managed-care folks will discover they can get such refractions cheaper than an eye exam. Managed care already tells the patients who to see and how often. If managed care decides that optician refractions are OK for routine care and that people only need a doctor's eye exam every four or five (or six or eight!) years, how many surplus O.D.s are there going to be then?

We must make sure our state leaders keep this matter uppermost in mind. History has shown that wars fought on two fronts are rarely won; lasers, orals,

injectibles and so forth, must not be won at the expense of traditional refractive care.

Dr. Phillips is in solo practice. Since graduating in 1975, he has practiced in a military hospital, private optometry offices, private ophthalmology offices and in an independent retail optical store. His e-mail is philoptom@aol.com

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2. Phillips D. Why Opticians Won't Refract. Eyecare Bus 1997; 12(8): 34-8.
3. Appler T. "Opticians Are Refracting." Eyecare Bus 1997; 12(8) 34-8.
4. Too Many O.D.s, Too Many M.D.s, Rand study finds. Rev Opt. 1994; 131(12):5.
5. Feds Start Anti-Residency Program. Rev Ophthalmol 1997; 4(10):6.

The Challenge Posed by Refracting Opticians

Paul Farkas

01-10-2006 from ODwire.org

With the acceptance of extremely accurate Automated Refracting Instrumentation, the basic refraction in many busy OD and OMD offices are being managed by Ophthalmic Technicians. These individuals, in most cases, have minimum Optometric Professional Education and their technical skill is developed by "on the job training".

In most private offices, the licensed OD or OMD decides the final eyeglass prescription. This improved automation has reduced the patient time with the OD and OMD on the tedious and time-consuming aspect of the refraction. Now more doctor time is available to the important eye health evaluation and case analysis.

As long as there is Optometric or Medical supervision of the minimally professionally educated Refracting Technician there is little threat to quality patient care. But now there is an attempt to change this established mode of practice.

The US Ophthalmic Dispenser would now like to have the opportunity to upgrade their status to become Refracting Opticians. They point to fact that with advanced automation refraction is a very routine straightforward procedure. They can point to the fact that there are Refracting Opticians world wide, including Canada. Why not the USA?

There is almost uniform optometric agreement that at the present time the education of the Ophthalmic Dispenser is inadequate to upgrade their responsibilities. Education ranges from a maximum of 2 years in a community college to no formal technical education. Not all States license Ophthalmic Dispensers. Without Education and Training how can the ophthalmic dispenser expect to make Independent Eyeglass Prescription judgements?
Will there be confusion on the part of the Public as to qualifications? Of course! How will eye pathology be discovered with no professional training and the inability to use diagnostic eye drops for dilation? This deficit certainly cannot be in the Public interest.

What should US Organized Optometry do? The knee jerk reaction is to set up roadblocks and fight every attempt to allow Opticians to expand their license. This roadblock approach was and still is used by Organized Medicine from the very earliest days of Optometry up to the present time.

Each time Optometry wishes to expand their professional services offered to patients, organized OMDs give a very similar argument that ODs might give when it comes to

Opticians expanding their license. This roadblock action did not work for Medicine because Optometry was well organized and backed their request for added patient responsibility, by additional education both in the Optometry colleges as well as at continuing education seminars.

Suppose Opticians become well organized? What if they can increase their education so that their training would be equal to the Optometrist who graduated in the first half of the 20th century? Would we offer the same arguments that some very Senior Optometrists can still remember? " Mr. Optometrist if you want to become an Eye Doctor, go to Medical School! " Will Organized Optometry now say "Mr. Optician, If you want to be an OD, go to Optometry School! ". Is this being hypocritical?

No matter what ODs or OMDs think, what the Opticians will be allowed to do is in the hands of State Legislatures. Would not the profession and Public be better served to accept the fact that Economics and the Market place will dictate which of the O's do what?

It may be that in the not too distant future, there will be a new pecking order with the least trained being the Ophthalmic Dispenser. Next there may be a new entity called the Refracting Optician or Refracting Optometrist working in Optical Locations. They will be supervised by the Optometric Physician who will be the Primary Care Eye Physician, responsible for the management of the eye patient having the Optometric Specialties under their control as well as manage office based eye pathology. They will refer all optical work to the Optical Centers and the refractionist and will no longer be involved with eyeglass dispensing. A small number of elite Ophthalmic Surgeons will offer care in the Ophthalmologic sub- specialties in Hospital based locations.

Isn't this the direction Optometry has been moving during the past 30 years to become the Primary Eyecare Provider? The Optometric Physician will be the entry point and control the disposition of the eyecare patient. How best to accomplish this goal?

If Ophthalmic Dispensers wish to improve their status they must be willing to sacrifice effort, time and money to become educated and trained to pass rigid state Board requirements. ODs as well as OMDs should be participating in the education and training and certification of this new class of Refracting Optician.

Optometry Colleges should consider expanding their roll by offering these course for the Refracting Optician. Of course the number of Optometric Physician slots would have to be decreased. All Optometric Physicians would automatically be expected to participate in Optometric Residency Programs.

Medical Residency training for OMDs would concentrate on the sub –specialties, leaving what was traditional Office Ophthalmology in the hands of the Primary Care Optometric Physician. The new Specialized OMD would be Hospital Based.

Are these proposal far fetched? Perhaps, others can design even more practical approaches. I did after all come up with these ideas in one afternoon. What is important is to understand that the clock for Optometry, Ophthalmology and now Ophthalmic Dispensing cannot be turned back. Technological advancements and the reality of the market place demand addressing needed changes. Optometrists must always keep the public interest as the most important factor in the decision making process.
I look forward to learning and discussing other points of view.